Sedgwick CMS

ASRS Long Term Disability
Direct Deposit Authorization Form

PART 1: To be Completed by Employee

Employer: ARIZONA STATE RETIREMENT SYSTEM

Employee: First Name _____Middle Initial_____ Last Name_____

SSN: _____

Agreement

I authorize Sedgwick CMS and my Employer, at their discretion, to deposit my approved disability benefit payments into my account as indicated below.

This authorization will remain in effect until I give written notice to Sedgwick CMS either to change or cancel this authorization, in such time and in such manner as to afford Sedgwick CMS a reasonable opportunity to act on it. I understand that my deposit will not be posted to my account until the date of my monthly benefit payment.

I have provided Sedgwick CMS with a form completed by my financial institution solely for the purpose of verifying my account number and transit/routing information.

I grant Sedgwick CMS and my Employer the right to correct any Electronic Funds Transfer resulting from erroneous overpayment by debiting my accounts to the extent of such overpayment. I further understand that Sedgwick CMS or my Employer is not responsible for any costs or service charges incurred by me as a result of Sedgwick CMS' actions related to Electronic Funds Transfer.

Action Requested

☐ Please establish a **NEW** direct deposit to the bank and account listed below.

☐ Please **CHANGE** my direct deposit, and direct my benefit payments to the bank and account listed below.

☐ Please **CANCEL** the direct deposit of my benefit payments to the bank and account listed below and send my benefit payment check to me in the mail.

_____ _____

Employee Signature Date

PART 2: To Be Completed By Employee's Financial Institution

Name of Financial Institution: _____

Routing #: ☐☐☐☐☐☐☐☐☐ Telephone #: (☐☐☐) ☐☐☐-☐☐☐☐

Account #: ☐☐☐☐☐☐☐☐☐☐☐☐ Type of Account: ☐ Checking ☐ Savings

Bank Employee Signature: _____ Date: _____

After completing this form, please **fax it to Sedgwick CMS at (818) 591-7664** or mail it to **Sedgwick CMS, PO Box 9830, Calabasas, CA 91372-0830**. Sedgwick CMS only needs one copy of this form, so please choose one method of delivery only.

For Sedgwick CMS Use Only

Prenote Completed By: _____ Date: _____